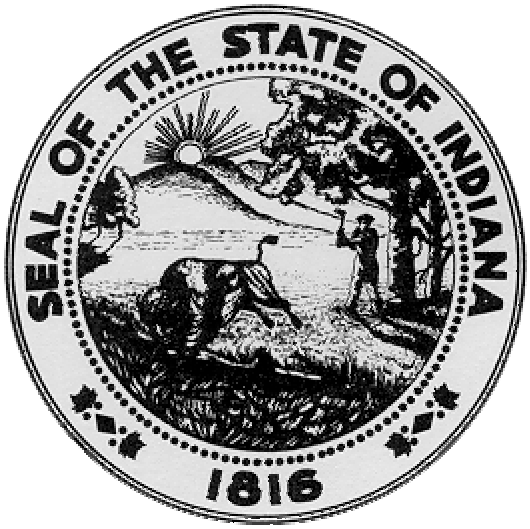

S e c t i o n
— 125 —
Flexible Benefits

Employee Information Packet Contents:

- How Flex Works — Increase your take home pay!
- Information about the ***Flex Convenience***® Debit Card ***NEW!***
- Frequently Asked Questions
- Plan Specifics Page
- Sample Claim Form
- List of Eligible Flexible Spending Account Expenses
- Tax Savings Worksheet — Find out how much <u>you</u> can save
- Election Form / Pre-Tax Salary Reduction Agreement

KEY
BENEFIT ADMINISTRATORS, INC.

P.O. Box 55210
Indianapolis, IN 46205-0210
317-218-1300
www.keyqualifiedplans.com

Qualified Plans Division

flexible spending accounts
healthcare savings accounts
group retirement plans

Is a Flexible Spending Account Right For You?

	YES	NO
• Do you, your spouse, or dependent children have out-of-pocket costs associated with the State's medical plan? (i.e. co-payments, deductibles, co-insurance)	☐	☐
• Do you, your spouse, or dependent children have other out-of-pocket medical care expenses not covered by insurance?	☐	☐
• Do you, your spouse, or dependent children have out-of-pocket dental expenses? (i.e. cleanings, fillings, orthodontia, etc.)	☐	☐
• Do you, your spouse, or dependent children have out-of-pocket vision expenses? (i.e. exams, glasses, contact lenses & cleaning solution, LASIK, etc.)	☐	☐
• Do you have Child/Dependent Day Care expenses that allow you and your spouse (if married) to be gainfully employed or attend school?	☐	☐

If you answered **YES** to any of these questions, you can reduce the taxes that you pay by participating in your employer sponsored Flexible Benefits Plan and therefore **increase your take home pay!**

What is a Flexible Spending Account?

A Flexible Spending Account is approved under Section 125 of the Internal Revenue Code. It enables you to pay for certain expenses with pre-tax dollars.

Types of Flexible Spending Accounts:

I. **Health Care Flexible Spending Account (FSA)** — Health care costs include medical, dental, vision and hearing expenses that are not paid by insurance and other "out-of-pocket" expenses for you, your spouse, and any dependent children. These expenses must be incurred within the plan year. These expenses include, but are not limited to, expenses for medical plan co-payments, deductibles, prescriptions and over-the-counter drugs (for the treatment of an injury or illness), physician visits, chiropractic care, vision, and dental/orthodontia care.

II. **Dependent Day Care Flexible Spending Account (FSA)** — Dependent Day Care costs include most dependent day care expenses for eligible children and adults. Qualified expenses include fees for adult and childcare centers, pre-school, and before and after school care. To be eligible you and your spouse (if married) must be employed or attend school. Your dependent must be under age 13 or physically and/or mentally incapable of caring for him or herself.

How Flex Works

	Without Flex	**With Flex**
Annual Income	$ 30,000	$ 30,000
Out-of-Pocket * Pre-Tax Expenses	0	$ 3,000
Remaining Income To Be Taxed	$ 30,000	$ 27,000
Estimated Taxes (26%) FICA, Federal & State **	$ 7,800	$ 7,020
Out-of-Pocket After-Tax Expenses	$ 3,000	0
Take Home Pay	$ 19,200	$ 19,980
YOUR ANNUAL TAX SAVINGS	**$ 0**	**$ 780**

Please Note: **The example shown above is for illustrative purposes only.**

* *The expenses in this example include Insurance Premiums, Health Care FSA and Dependent Day Care FSA.*
** *Varies According to State Regulations*

The above example illustrates the advantage of participating in your employer's Flexible Benefits Plan. This illustration demonstrates how a participating employee might save **$780** in taxes during the Plan Year by paying for his expenses with pre-tax dollars.

The *Flex Convenience*® Debit Card

Frequently Asked Questions

What is the Flex Convenience® Card?
The Flex Convenience® Card (FlexCard) is a debit card offered to enhance your Flexible Spending Account by providing instant access to your healthcare FSA account. The card is designed for use only at qualified providers or merchants that accept MasterCard and offer eligible goods or services for reimbursement under your healthcare Flexible Spending Account. Rather than paying out-of-pocket money for qualified expenses and waiting for reimbursement, your FlexCard transfers funds for qualified expenses directly from your available healthcare Flexible Spending Account to the provider. As a Flexible Spending Account participant, a FlexCard will be mailed to your home address.

How does the FlexCard work?
The FlexCard is an off-line debit card that allows you to pay for your eligible FSA expenses directly at the point of service. The FlexCard is treated like a credit card at a merchant or provider terminal because it does not require a P.I.N. number before processing a transaction. There is no additional line of credit associated with the card, and no credit check will be performed.

Will I still need to provide any follow-up transaction detail?
Yes, in many cases we may request information in order to verify the eligibility of your FlexCard purchase. Automated follow-up letters will be sent to you via e-mail should transaction detail be required. You simply fill in the blanks as directed and e-mail or fax back to *KBA* for review. If you do not provide *KBA* an e-mail address on your election form, the transaction detail request will be mailed to your home address.

Where may I use my FlexCard?
You may use your card to pay for eligible FSA expenses at your doctor or dentist's office, the hospital, pharmacy or vision provider. You may use your card for eligible FSA expenses such as co-pays, deductibles, out-of-pocket expenses, and other expenses that are not eligible under your medical, dental or vision plan but are eligible FSA expenses. Visit our website at **www.keyqualifiedplans.com** for a listing of eligible expenses. Please note, you may not use your FlexCard towards "Paid on Account" or "Balance Forward" amounts.

What happens if I try to charge $50 but I only have $30 left in my available account balance?
The transaction would be denied. You may ask the provider to only charge the $30 on your FlexCard and pay the balance with another form of payment. You may check on your current account balance on-line prior to using your FlexCard to verify your available balance.

What if my provider doesn't have a charge card terminal?
You can still utilize funds from your account using the traditional method (you pay the provider, submit a claim form and detailed invoice/receipt, and receive reimbursement via check) by mailing or faxing your claim paperwork to your FSA administrator.

What do I do if my card is lost or stolen?
You should immediately contact a *KBA* Customer Care Representative at 317-218-1300 or toll-free at 866-387-0493 to report your FlexCard lost or stolen. You will receive a replacement card within 7-10 days.

Where can I view my Flexible Spending Account history?
Go to **www.keyqualifiedplans.com** and click on "Flexible Spending Accounts", then "Secure FSA Account Access". After following the instructions to "Create Account", you will be able to check on your current account balance, request statements on demand, and review your detailed transaction history.

The *Flex Convenience*® Debit Card

Claims Procedure

You may use your Flex Convenience® Debit Card (FlexCard) at pharmacies, doctor's offices, and hospitals…wherever you incur eligible Flexible Spending Account expenses. Although the FlexCard provides direct access to your FSA dollars, it does not eliminate the need for your *KBA* administrator to verify the eligibility of the item(s) purchased.

- **Purchase Substantiation** — In order to confirm the eligibility of all expenses charged to your FlexCard, occasionally you may be asked to provide supporting information about your purchase. *KBA* follows the IRS-defined Flexible Spending Account debit card audit guidelines.

- **Co-Payment Purchases** — When your total FlexCard purchase is for an amount exactly equal to your employer's medical plan co-payment, no further purchase substantiation is required; however, you should still keep copies of all receipts for your personal records.

- **Transaction Follow-Up** — When purchase substantiation is required, you will be sent automatically a follow up letter via e-mail (or U.S. mail) requesting fill-in-the-blank transaction detail.

- **Ineligible Expenses** — Should your transaction detail reflect your FlexCard purchase was for ineligible expenses, or if the necessary documentation was not provided to the Plan Administrator in a timely manner, the transaction will be considered "denied/ineligible" and you must reimburse *KBA* for the amount charged to the FlexCard.

***Example #1* — Employee Substantiation Not Required (Eligible Expense)**

Joe Participant uses his FlexCard at the pharmacy to pay for his generic drug prescription. His medical plan co-pay is $10.00 for a generic drug prescription, so his total purchase at the pharmacy came to $10.00. Joe pays for this purchase with his FlexCard and is not required to provide further purchase substantiation since the total purchase exactly equaled his applicable medical plan co-payment.

***Example #2* — Employee Substantiation Required (Eligible Expense)**

Joe Participant uses his FlexCard at the pharmacy to pay for his generic drug prescription, a bottle of contact lens cleaner (both are eligible FSA expenses). His medical plan co-pay is $10.00 per generic, and the contact lens cleaner is $6.78. His total purchase at the pharmacy came to $16.78. Joe pays for this purchase with his FlexCard, but will be required to provide purchase substantiation since the purchase was not solely for his medical plan co-payment. Joe would receive the transaction detail request via e-mail (or USPS mail) and simply reply directly to the e-mail, or complete and fax back to *KBA* for review. *KBA* Customer Care would verify that both the prescription co-payment and the contact lens cleaner are eligible flex expenses.

***Example #3* — Employee Substantiation Required (Ineligible Expense)**

Joe Participant uses his FlexCard at the pharmacy to pay for a bottle of multi-vitamins for $5.82 (vitamins for general wellness are NOT eligible). Joe would receive the transaction detail request via e-mail (or USPS mail) and simply reply directly to the e-mail, or complete and fax back to *KBA* for review. *KBA* Customer Care would determine the purchase of multi-vitamins was not an eligible expense and would then notify Joe that he must reimburse the plan for $5.82 or any future claim(s) would be reduced by that amount. Joe's FlexCard would be deactivated until repayment is received by *KBA* or sufficient eligible traditional claims are submitted to offset the ineligible FlexCard charges.

Flexible Spending Accounts

Frequently Asked Questions

This packet is only a brief overview of benefits that may be eligible under your plan. You should consult your Summary Plan Description for specific information about your plan.

Who can participate in the Plan?

All employees who have met the eligibility requirements established by your employer may participate in the Plan.

How do I sign up?

Your employer will give you the opportunity to sign up prior to each effective date of the Plan, provided you have fulfilled the eligibility requirements.

How do I determine how much money to allocate?

Be conservative! Only consider your known expenses. Do not allow for things that might happen. For dependent day care, do not forget to consider vacations or times you will not be paying the dependent day care provider. A list of eligible expenses and a worksheet are provided to help you calculate your expenses for the upcoming plan year.

Are there limits?

Yes, the maximum annual amount for the Dependent Day Care FSA is $5,000 ($2,500 if you are married and filing separate tax returns). The maximum annual amount for the Health Care FSA is also $5,000 for the 2004 plan year.

I went to the doctor before the plan year began, but I did not pay the expense until after the plan year started. May I include that expense?

No. Services must be incurred within the plan year. The date of payment does not matter.

Can I change my annual allocation anytime during the Plan Year?

You may change your annual allocation if you have one of the eligible status changes as defined in your Employer's Plan. Examples of qualifying changes in status are marriage or divorce, death of a spouse or dependent, birth or adoption of a child, and change in your employment or in your spouse's employment. Status changes must be consistent with the status change event. Please consult your Summary Plan Description for complete details.

What happens if I do not use all of my annual allocation?

The IRS has established a "use it or lose it rule". If you do not use all of your annual allocation, you will forfeit any remaining amount. For example, if you allocate $500 and only submit $450 in expenses, you will lose the $50 (not just the taxes.) So, please be conservative when you determine your annual allocation.

Can I sign up for the Dependent Day Care plan and still take the Dependent Day Care tax credit on my annual tax return?

The amount you pledge towards the Dependent Day Care account reduces the amount you can claim as a tax credit, dollar for dollar. Most employees (depending on your family income) will experience a higher tax savings on the Dependent Day Care Plan. You should consult with your accountant to see which option works best for your situation.

What happens if I terminate my employment?

You may still submit eligible receipts for expenses incurred within the time frames established by your Employer. Also, you may be eligible to continue coverage under the Health Care FSA option through federal COBRA regulations.

How do I submit a claim for reimbursement?

Copies of receipts for Health Care FSA expenses must be submitted with a signed claim form. The receipts must be independent third party receipts showing the date of service, the type of service, the amount of the service and the patient's name. If the expense is covered by your insurance company, please submit the receipt to the insurance company first. You may then forward a copy of the Explanation of Benefits from the insurance company along with the signed claim form to KBA™. Cancelled checks are not eligible as receipts for Health Care FSA expenses.

For Dependent Day Care FSA expenses, send a signed claim form along with copies of statements or receipts which show the day care provider's name, the dates of service, the amount of the service and the dependent's name to KBA™.

Claim forms, including detailed receipts/invoices, may be faxed for processing to (317) 284-7269 or (866) 241-1488.

Will I receive information throughout the year telling me where I stand on my account?

Yes, you will receive periodic reports showing what has been credited to your account. You will also receive a reminder letter before your plan year ends, if you have a balance in your account.

Will my participation in the Flex Plan affect my Social Security?

You will not pay Social Security taxes on the money you contribute to the Flex Plan. Therefore, your future Social Security benefits may be slightly reduced. However, the tax savings you receive from this plan should be more than any reduction in your Social Security benefits.

State of Indiana

Section 125 Plan Specifics

PLAN YEAR:		1/01/04 - 12/31/04
PLAN OPTIONS:		PLAN MAXIMUMS:
Health Care FSA Plan Option		$ 5,000
Dependent Care FSA Plan Option		$ 5,000 ($416.66 per month)
PARTICIPATION IN THE HEALTH CARE FSA PLAN OPTIONS:		May begin after meeting Eligibility requirements.
PARTICIPATION IN THE DEPENDENT CARE FSA PLAN OPTIONS:		May begin after meeting Eligibility requirements.
PARTICIPATION AFTER TERMINATION IN THE HEALTH CARE FSA PLAN OPTION:		Terminated employees will be allowed 0 days to incur expenses and an additional 30 days to submit expenses.
PARTICIPATION AFTER TERMINATION IN THE DEPENDENT DAY CARE FSA PLAN OPTION:		Terminated employees will be allowed 30 days to incur expenses and an additional 60 days to submit expenses.
CLAIMS SUBMISSION:		Claims must be submitted by noon E.S.T. two business days prior to the next check run date.
CLAIMS SUBMITTED AFTER THE END OF PLAN YEAR:		Claims must be submitted no later than 90 days after the end of the Plan Year.
STATUS CHANGE NOTIFICATION TIME FRAME:		Status changes must be submitted within 30 days of the Qualifying Event
KBA CUSTOMER CARE PHONE SUPPORT:		(317) 218-1300, or toll-free (866) 387-0493
24/7 ONLINE ACCOUNT ACCESS:		www.keyqualifiedplans.com
SUBMISSION OF FLEX CLAIMS:	By Fax:	(317) 284-7269, or toll-free (866) 241-1488
	By Mail:	KBA Flex Department Qualified Plans Division P.O. Box 55210 Indianapolis, IN 46205-0210

Section 125 FSA Claim Form

THIS FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Employer: _____

Employee Name: _____ Soc. Sec. #: _____
Last First MI

Home Address: _____ _____ _____ _____
Number/Street City State Zip

Daytime Phone: _____ ☐ **Please check if new address**

The following reimbursement request rules apply:

Healthcare and/or dependent care expenses must be **incurred** within the appropriate Plan Year and prior to reimbursement. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. Cancelled checks are not acceptable receipts. **This form must be signed and accompany each group of receipts submitted.** You may submit receipts by mail or fax.

Healthcare receipts must be from an independent third party and must include the following information:

- **Name of Provider**
- **Type of Service/Supply Provided (Names of Prescriptions required)**
- **Date of Service/Purchase**
- **Charge for Each Service/Supply**
- **Name of Patient**

Expenses that may be covered by your (or your spouse's) medical, dental or vision plan **must** first be submitted to the appropriate insurance carrier. The Explanation of Benefits (E.O.B.) you receive from your insurance carrier may then be submitted to *KBA*™ as a qualifying receipt toward your *KBA*™ Plan.

Number of Health Care claims attached _____

Total dollar amount to be applied to your *KBA*™ Health Care FSA account $_____

Dependent Day Care receipts must include the following information: Name of Provider, Date of Service, Name of Dependent and Fee for Service OR have your Dependent Day Care provider complete and sign below (original signature required).

Dependent's Name _____ Date of Birth ____/____/____

Dependent Day Care Provider _____ Tax ID or SSN _____

Dates of Service ____/____/____ through ____/____/____ Total Amount $_____

_____ _____
Dependent Day Care Provider Signature Date

Number of Dependent Day Care claims attached _____

Total dollar amount to be applied to your *KBA*™ Dependent Day Care FSA account $_____

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. If this claim includes medical expenses, I certify that these expenses have not been previously reimbursed nor will I seek reimbursement from any other source. I authorize my Flexible Spending Account(s) be reduced by the amount requested.

Attention *Flex Convenience* MasterCard users:

- ☐ **None** of the attached claims were purchased using the *Flex Convenience* MasterCard
- ☐ **Some** of the attached claims were purchased using my *Flex Convenience* MasterCard (Please write "FlexCard" on claim(s) purchased with your *Flex Convenience* MasterCard)
- ☐ **All** of the attached claims were purchased using my *Flex Convenience* MasterCard

Employee's Signature _____ **Date** _____

Please submit this form & receipt(s) by Mail:
KBA Flex Dep't / Qual Plans Division
P.O. Box 55210
Indianapolis, IN 46205-0210

Or submit via by Fax: **317-284-7269**, or **866-241-1488**

Questions about this form? Contact *KBA* Customer Care at 317-218-1300 or toll-free at 866-387-0493.

35K-041(7-03)

What Type of Expenses Are Eligible?

Health Care FSA Expenses

The following list, while **not intended to be complete**, illustrates expenses that **may** be reimbursed under the Health Care FSA; restrictions may apply.

CO-PAYMENTS / DEDUCTIBLES / CO-INSURANCE

PRESCRIPTION & OVER-THE-COUNTER DRUGS *(For the treatment of an injury or illness)*

DENTAL EXPENSES
- Routine & Preventive Services
- X-rays
- Orthodontia *(generally as treatment is provided)*
- Restorative services, fillings, extractions, dentures

VISION CARE EXPENSES
- Eye exams
- Prescription eyeglasses & sunglasses
- Contact lenses & supplies
- Corrective surgery *(RK & LASIK)*

MEDICALLY NECESSARY EQUIPMENT
- Wheelchair & lifts
- Crutches
- Oxygen equipment & supplies
- Blood pressure monitor

DIABETIC SUPPLIES
- Insulin
- Test strips, lancets, etc.
- Glucose monitor

PHYSICAL EXAMINATIONS
- Annual physical exam *(including prostate screening, pap smears & mammograms*)
- School & work physicals

COUNSELING & PSYCHIATRIC TREATMENT
- Psychologists
- Psychotherapists
- Psychiatrists

FEES & SERVICES
- Physicians, surgeons, anesthesiologists, OB/GYN
- Ambulance
- Nursing *(including room & board)*
- Chiropractic services
- Fertility treatment
- Sterilization & reversals
- Medically necessary reconstructive services *(i.e. mastectomy or following an accident)*
- Hospital expenses

HEARING EXPENSES
- Testing
- Hearing aids
- Batteries & repairs

OTHER EXPENSES
- Prosthesis & artificial limbs
- Organ tissue donation expenses
- Tuition at special school for handicapped
- Travel necessary to seek medical treatment *(limitations apply)*
- Orthotics & orthopedic shoes *(medically necessary)*
- Laboratory fees
- Acupuncture
- Alcohol & drug rehabilitation expenses
- Special equipment for those who are deaf and/or blind *(i.e. Braille books, hearing devices, guide dogs)*
- Weight loss programs and drugs *(when prescribed by a doctor to treat obesity and/or a medical condition – statement required from the doctor)*
- Smoking cessation program or prescribed drug
- Medical supplies
- Therapy treatments *(when prescribed by a doctor)*

The following list illustrates some of the Health Care expenses that are NOT ELIGIBLE under the Plan:

Cosmetic treatments or surgery *(unless necessary to alleviate a deformity related to a congenital abnormality, trauma, or disfiguring disease)*
Expenses *(treatments and drugs)* only to improve your general health or well being
Hair replacement treatments and drugs
Health club dues
Long Term Care Insurance
Marriage & family counseling
Nutritional supplements for general wellness
Teeth whitening
Vacations
Vitamins to improve or preserve general health *(even when prescribed/recommended by a doctor)*
Weight loss programs/drugs to improve or preserve general health *(even when prescribed/recommended by a doctor)*

Dependent Day Care FSA Expenses

Dependent Day Care FSA **ELIGIBLE** expenses include expenses necessary for you and your spouse (if married) to be gainfully employed or attend school. Eligible expenses include:

Expenses paid for the care of a dependent under age 13
Expenses paid for the care of a dependent who is physically or mentally incapable of caring for himself or herself
Expenses paid to a dependent day care provider
If you are divorced, your child must be in your custody for at least six months out of the year

The following list illustrates some of the Dependent Day Care expenses that are NOT ELIGIBLE under the Plan:

Kindergarten
Field trips, lunches, supplies, and transportation fees
Overnight camps
Care for dependent who lives outside of the employee's home
Registration fees

How Much Can I Save?

Employee Tax Savings Worksheet

I. Health Care FSA Expenses:

Estimated family annual medical/dental/vision expenses **not covered** by insurance:

Co-pays, deductibles, co-insurance	$ _____
Prescription & eligible O.T.C. drugs	$ _____
Doctor office visits	$ _____
Physical exams	$ _____
Well-baby care	$ _____
Chiropractic care	$ _____
Dental care	$ _____
Orthodontia	$ _____
Vision Exams	$ _____
Eyeglasses, Contact lenses, solution	$ _____
Insulin and related supplies	$ _____
Hearing care	$ _____
Other Medical Expenses	$ _____

Total Annual Medical, Dental, Vision Expenses: $ _____

II. Dependent Day Care FSA Expenses

Weekly expenses $ _____

x 52

Total Annual Dependent Day Care Expenses: $ _____

III. Total Flex Savings

Total eligible annual expenses from above $ _____

Multiply by an estimated tax savings of 26% x 26%

Your Estimated Annual Tax Savings **$** _____

Section 125 Flexible Spending Account

Election Form and Pre-Tax Salary Reduction Agreement

I. Employer Name: _____ Effective: ____/____/____ - ____/____/____

Employee Name: _____
(Please Print) FIRST MI LAST

Address: _____ SSN: _____

_____ ____ _____ Date of Birth: _____
CITY ST ZIP

E-mail Address: _____ Daytime Phone #: _____

# of Pay Periods per year: _____ Department: _____

Payroll Cycle: _____ For example: **A**, **B**, **Quasi-Agency** (please note which one) or **Direct-Bill**

II. Pursuant to my Employer's Flexible Benefits Plan ("Plan"), I elect to have my salary reduced by the total pre-tax amount specified below. I authorize my Employer to apply that amount toward those plan benefits listed on this form with the total to be distributed among each benefit as shown.

Health Care Flexible Spending Accounts Expenses (# of deductions _____)

Health Care Expenses $ _____ Per Pay Period **Health Care FSA**
(Items not paid by insurance) **Plan Year Total $** _____

Dependent Day Care Flexible Spending Account Expenses (# of deductions _____)

Dependent Day Care Expenses $ _____ Per Pay Period **Dependent Day Care FSA Plan Year Total $** _____

III. **I UNDERSTAND AND AGREE THAT:**

1. I cannot change or revoke my election until the next Plan Year unless my Status changes (as defined in my Employer's Plan). I understand my benefit elections may not be reduced below the amount that has been taken pre-tax as of the date of the status change.
2. Any funds remaining in my reimbursement accounts at the end of the plan year will be forfeited by IRS regulations to my employer.
3. If my employment terminates for any reason, I understand expenses must be incurred and submitted within the time frames set out in the Plan.
4. I understand that any receipt I submit must be for an eligible expense incurred during the specific Plan Year.
5. Before the first day of each Plan Year, I will be offered the opportunity to modify my elections for the following Plan Year.
6. My Employer may reduce or cancel the election of any non-taxable benefit or otherwise modify my election in accordance with the Plan if my Employer in its discretion, deems that action advisable to satisfy the requirements of the Internal Revenue code or the regulations thereunder.
7. By signing and using the *Flex Convenience*® debit card (the Card), if so provided by my employer, I accept responsibility that all Card transactions will be solely for qualified expenditures incurred within the Plan Year. Each time I present the Card for payment, I will sign a receipt evidencing that the expense has been incurred and reaffirming that it is a qualified expenditure that has not been reimbursed, nor will any reimbursement be sought from any other source. Upon request, I will immediately submit any required documentation and/or transaction detail. I understand that if I use the Card for purchases other than qualified expenditures, I have violated this Agreement and my obligations under my Employer's Plan. I understand that, upon notification, I must immediately re-pay the expense to the Account and that my Card may be immediately suspended or revoked for such failure to comply.

_____ _____
Employee Signature Date